

2009 STUDENT AMBASSADOR FORMS

HEALTH FORM

In an effort to accommodate the individual needs of each of our Ambassadors, we ask that the delegate's parent or guardian complete the following Health Form. All information is confidential and may only be released to People to People program staff. In the event of an emergency, information provided can be given to the appropriate medical authority.

Program _____ Today's date _____
Delegate name _____ Delegate ID# _____
Delegate address _____
Phone (_____) _____ Date of birth ____/____/____ Gender ☐ Male ☐ Female

Does your child currently have any of the following conditions or symptoms?

An acute medical issue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Severe vision impairment (not corrected by glasses or contacts)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures or epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Severe hearing impairment (not corrected by hearing aids/implants)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental health issues (i.e. depression, mood disorders, anxiety, eating disorders, ADD, ADHD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mobility limitations	<input type="checkbox"/> Yes <input type="checkbox"/> No		

If you answered "Yes" to any of the above items, please explain below:

Condition	Detailed Description
_____	_____
_____	_____
_____	_____
_____	_____

Medications

Describe in detail any medications or treatment your child will be using while on the program. None ☐

Medication	Reason	Medication	Reason
_____	_____	_____	_____
_____	_____	_____	_____

Allergies

Allergy	Reaction	Medication Required	Life Threatening?
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

For allergic emergencies, my child carries auto-injectable epinephrine (i.e. EpiPen®) ☐ Yes ☐ No

Dietary Requests

Please understand that we cannot guarantee certain meal requests. None ☐

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HEALTH FORM

[illegible]

Print name